

**ANNEXURE V****F M C NETWORK UAE**

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
 Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim formDate: **24-Oct-2023**

Clinic Name: **Irham Medical Center Arjan** Emirates: **784-2005-0983639-9**
 Card Holder's Name: **RUPINDER KAUR BANSAL** Age: **18Y - 0M - 28D** Sex: **Female**
 Card Holder's Tel No: Mobile No: **0504984722**
 Ins Card No: **I011-010-115974673-01** Valid Upto: **13/8/2024**
 Company **FMC NETWORK UAE** Employee _____ Nationality: **Indian**
 Name: **MANAGEMENT CONSULTANCY** No: _____



Clinical Details: Temp **37.1** B.P. **100** Pulse. **92**
 Signs & Symptoms: **Risk of Fall**
 Date of Onset Illness : _____ ☐ Emergency ☐ Work related ☐ New visit ☐ Follow
 Diagnosis: **J20.9 - Acute bronchitis, unspecified, J01.00 - Acute maxillary sinusitis, unspecified, J02.9 - Acute pharyngitis, unspecified, E86.0 - Dehydration**

Management plan (Services inside the clinic including injections and investigations)

**2849-100143-0991, 5% W/V DEXTROSE 0.45% & W/V SODIUM CHLORIDE , Pharmacy,0125-122107-1022, DEXAMETHASONE S
 PHOSPHATE-(DEXAMETHASONE : 4 MG/ML) SOLUTION FOR INJECTION , Pharmacy,0005-111805-1021, CHLOROHISTOL 10MG
 Pharmacy,0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,96365, IV Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr - (AE
 Co.Pay,96374, THER/PROPH/DIAG INJ IV PUSH , Co.Pay,94640, AIRWAY INHALATIC
 Pharmacy,0006-124513-2071, VENTOLIN NEBULES , Pharmacy,9, Consultation Gp ,**

Doctor's Name: **Sajid Sanaullah**

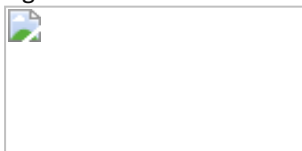
signature with seal:

Dr. Sajid Sanaullah
 General Practitioner
 DHA No: 0575821
PESHAWAR MEDICAL
 DUBAI - U.A.E.

Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the ab
 mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy o
 person who has provided medical services to me to furnish any and all information with regard to any medical history, medical c
 medical services and copies of all medical and Clinic records.

Signature of the Patient

Date **24-Oct-2023**Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quant
(SALBUTAMOL(AS SULPHATE) : 1 MG/ML) NEBULIZING SOLUTION	NEBULIZING SOLUTION (2.5ML X 40, NEBULES)	5	20
(CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS	TABLETS (20S, BLISTER PACK)	7	14
(MONTELUKAST (AS SODIUM) : 10 MG) FILM COATED TABLETS	FILM COATED TABLETS (100S, BLISTER PACK)	14	14

Medicine	Dose	Duration	Quant
(FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS	FILM COATED TABLETS (15S, BLISTER PACK)	5	10
(BUDESONIDE : 0.5 MG/ML) SUSPENSION FOR NEBULIZATION	SUSPENSION FOR NEBULIZATION (2ML X 20, UNIT)	5	10